STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155752	A. BUILDING 00 B. WING	11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE NURSING AND MEMORY CARE CENTER	18325 BAILEY AVE SOUTH BEND, IN 46637

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000		F0000		

This visit was for Recertification and State Licensure Survey.

Survey dates: November 26, 27, 28, 29, and 30, 2012

Facility number: 004732
Provider number: 155752
AIM number: 200808300

Survey team:
Shelly Vice RN, TC
Carol Miller RN

Census bed type:
SNF 1
SNF/NF 34
Total 35

Census payor type:
Medicare 1
Medicaid 28
Other 6
Total 35

These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.

Quality Review completed on 12/07/12, by Brenda Meredith, R.N.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155752	A. BUILDING 00 B. WING	11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE NURSING AND MEMORY CARE CENTER	18325 BAILEY AVE SOUTH BEND, IN 46637

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155752	A. BUILDING 00 B. WING	11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE NURSING AND MEMORY CARE CENTER	18325 BAILEY AVE SOUTH BEND, IN 46637

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155752	A. BUILDING 00 B. WING	11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE NURSING AND MEMORY CARE CENTER	18325 BAILEY AVE SOUTH BEND, IN 46637

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.			
	Based on observation and interview, the facility failed to accurately post the local Ombudsman contact name and telephone number in the facility. This potentially affected 35 of 35 residents residing in the facility. Findings include: On 11/26/12 at 10:45 a.m., an observation was made in the front foyer entrance of the facility of a wall-flier-holder designated for the Ombudsman contact information. The name and contact information was telephoned at that time. A connection with the South Bend Area Ombudsman office was made. An interview was conducted at this time with an Ombudsman representative in the South Bend office. She indicated that the name and contact information was not	F0156	**F156 What corrective action will be accomplished for those residents found to have been affected by this deficient practice:** No residents were adversely affected by this practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:** No residents were adversely affected by this practice. **What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur:** The prior ombudsman name has been removed and the new ombudsman name is correctly in place in the foyer and dining/activity area. All visitors can see the name change in the foyer and dining/activity area. The	12/30/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155752	A. BUILDING 00 B. WING	11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE NURSING AND MEMORY CARE CENTER	18325 BAILEY AVE SOUTH BEND, IN 46637

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	accurate. She indicated that the Ombudsman listed on the contact information had, "...resigned in June of 2012." She indicated that,"...a memo letter had been sent to Morningside Nursing Home prior to the resignation of the previous person and the correct information for contacting an Ombudsman by the facility was provided." She also noted that she was now the most current Ombudsman representative. She indicated that she, "... had been in direct contact with the most current Administrator and the Administrator prior to the current." She stated, "... I am 100% sure they are aware of who their correct Ombudsman contact is and the information was provided to them." On 11/27/12 at 9:15 a.m., an observation was made in the front foyer entrance of the facility of a flier holder designated for the Ombudsman contact information. The name and contact information were unchanged. It was also observed at that time to have been inaccurately posted within the facility in the main dining room/ activity area/ front entrance along with the other advocacy and state contact numbers and addresses. The same inaccurate Ombudsman information that had been noted posted in the front entrance foyer area had also been posted		phone number for the ombudsman never changed and was correctly posted; only the name had changed. Residents and family members were always able to reach the ombudsman by telephone as needed. **How will the corrective actions be monitored to ensure the deficient practice will not recur, what quality assurance measures program will be put into place:** All future correspondence from the ombudsman will be acted upon by the administrator to ensure name changes are posted timely in the foyer and dining/activity area. The administrator will visually inspect the two postings for accuracy monthly for three months and immediately correct any know deficiency. Any deficiency will be reported to the Q/A committee and visual monitoring will be extended for another month.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155752	A. BUILDING 00 B. WING	11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE NURSING AND MEMORY CARE CENTER	18325 BAILEY AVE SOUTH BEND, IN 46637

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	within the facility On 11/28/12 at 8:45 a.m., an observation was made in the front foyer entrance of the facility of a flier holder designated for the Ombudsman contact information. The name and contact information were unchanged. It was also observed to remain inaccurately posted within the facility in the main dining room/ activity area/ front entrance along with the other advocacy and state contact numbers and addresses. On 11/30/12 at 3:30 p.m., an interview was conducted with the Administrator, the DNS (Director of Nursing Service), the SW (Social Worker), the Activities Director, the MDS (Minimum Data Set) nurse, the Dietary Manager and the Business Office Manager. It was noted that the information for the local Ombudsman office was inaccurate. The Administrator noted he was aware that the Ombudsman's name that was posted in the facility was not the accurate Ombudsman representative for the facility. 3.1-4(3)(C)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155752	A. BUILDING 00 B. WING	11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE NURSING AND MEMORY CARE CENTER	18325 BAILEY AVE SOUTH BEND, IN 46637

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155752	A. BUILDING 00 B. WING	11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE NURSING AND MEMORY CARE CENTER	18325 BAILEY AVE SOUTH BEND, IN 46637

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0356 SS=B	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation, interview, and record review, the facility failed to daily post the actual hours worked of the nursing staff and the resident census for 1 of 5 days (11/26/12) the posting was observed.	F0356	**F356 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** No residents were affected by this practice. **How other residents having the**	12/30/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155752	A. BUILDING _____ B. WING 00	11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE NURSING AND MEMORY CARE CENTER	18325 BAILEY AVE SOUTH BEND, IN 46637

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Findings include: On 11/26/12 at 10:45 a.m., an observation was made of the posting of the daily nursing staff which was located on the wall behind the nurse's station. The daily nursing staff was posted on a 'wipe-off-board' having used dry erasable markers. It contained the current date, the nursing staff currently on duty, the area of the facility the specific staff person was assigned to work for their shift. There was not a resident census nor a total number and actual hours worked for the licensed and unlicensed staff responsible for resident care. The posting indicated the current shift only. It did not include the off-going shift nor the oncoming shift. At this same time an interview was conducted with LPN #1 on duty. She indicated that the wipe off board was the daily posting of the nursing staff provided by the facility. She indicated that, "...yes, it is..." She also indicated the numbers written beside each staff persons name indicated, "...the area of the facility that the actual staff is assigned to cover for that specific shift." She also indicated that, "... a 3-ring-binder was located behind the nursing desk area that contained the form that the information was taken from for handwriting in dry erasable marker to the		**potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken**: No residents were affected by this deficient practice. **What measures will be put into pace or what systemic changes will be made to ensure that the deficient practice does not recur:** The current wipe off board located directly behind the nursing station will be updated to include the facility's name and logo, current date, and nurse staffing data for all three shifts. Each staff member providing direct will be identified as an RN, LPN, or CAN. The designated location of the wipe off board is clearly marked and visible to both staff, residents and visitors. The hours scheduled to work will be written on the dry erase board daily for nurses and nures aides.The facility utilizes employee enterprise to track hours worked for all hourly staff. Hourly staff is required to swipe in and out for each worked shift. Via Employee Enterprise a report will be run daily. This report identifies each staff member and actual hours worked. Totals are calculated for each category of employee. CNA, RN, and LPN total actual hours worked are calculated daily. These reports are reviewed by the Director of Nursing and then kept in the business office and upon written or oral request can be made	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155752	A. BUILDING 00 B. WING	11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE NURSING AND MEMORY CARE CENTER	18325 BAILEY AVE SOUTH BEND, IN 46637

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	wipe off board." A record review was made on 11/26/12 at 11:00 a.m. of the 3 ring binder mentioned above. It was noted to hold a daily nursing staff with the header, "Morningside Daily Staffing Shift." The information contained was as follows: 1) Facility name 2) Date 3) Census 4) Nursing staffing for each shift designated by hours worked e.g. "... Day Shift. Nurse 7-3:30... CNA 7-3.. Evening shift. Nurse 3 - 11:30...CNA 3- 11... Night Shift... Nurse 11- 7:30... CNA 11-7..." 5) Signature of staff assigned for the specific assignment correlating to their nursing title/ position. An interview was conducted with LPN#1 about the information on the form mentioned on previous note at 11:10 a.m. on 11/26/12. She indicated that the information on the forms found in the 3 ring binder were used to post information to the wipe off board every shift. She also noted the signatures indicated the staff had actually worked the designated shift they had been assigned. On 11/30/12 at 3:00 p.m. an interview was conducted with the Administrator,		available to the public. **How the corrective action(S) will be monitored to ensure the deficient practice will not recur. What quality assurance program will be put into place:** The Director of Nursing or designee will review the wipe off board daily for accuracy and review the Employee Enterprise report. The DON will correct any mistakes noted on the dry erase board immediatly and report any issues to the Q/A committee for two quarters. Further monitoring will be required if more than ten corrections need to me made in one quarter.**What date will the systemic changes be completed. Systemic changes will be completed by 12/21/12.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155752	A. BUILDING 00 B. WING	11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE NURSING AND MEMORY CARE CENTER	18325 BAILEY AVE SOUTH BEND, IN 46637

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the SW (Social Worker), the MDS (Minimum Data Set) nurse, the DNS (Director of Nursing Services), the Activities Director, the Medical Records Manager, the Dietary Manager and the Business Office Manager. It was noted by the Medical Records Manager that the facility had not provided the actual hours worked as indicated. 3.1-13(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155752	A. BUILDING _____ B. WING 00	11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE NURSING AND MEMORY CARE CENTER	18325 BAILEY AVE SOUTH BEND, IN 46637

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0455 SS=C	483.70(b) EMERGENCY ELECTRICAL POWER SYSTEM An emergency electrical power system must supply power adequate at least for lighting all entrances and exits; equipment to maintain the fire detection, alarm, and extinguishing systems; and life support systems in the event the normal electrical supply is interrupted. When life support systems are used, the facility must provide emergency electrical power with an emergency generator (as defined in NFPA 99, Health Care Facilities) that is located on the premises. Based on observation, record review and interview, the facility failed to make provision of a generator for back up electrical service for the facility. This had the potential to affect 35 of 35 residents residing in the facility in the event of a power outage. Findings include: On 11/29/12 at 10:00 am, the Administrator and the Activities Director were inquired about the facility's electrical emergency power supply in the event of a power outage to the facility. The Administrator indicated that the facility did not have an "emergency generator." He stated, "...we (the facility) have a generator but not a back-up generator..." When inquired about a functional power system used for	F0455	**F455 What corrective action will be accomplished for those residents found to have been affected by this deficient practice:** Ensure safety & emergency systems are maintained for all residents. **How other residents having the potential having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:** All residents have the potential to be affected and facility will institute systemic policy changes affecting the entire facility. **What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur:** The facility emergency generator & exit door policy has been updated (see attachments 1&2). A battery powered suction machine will be	12/30/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155752	A. BUILDING 00 B. WING	11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE NURSING AND MEMORY CARE CENTER	18325 BAILEY AVE SOUTH BEND, IN 46637

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	emergency back up power, the Administrator indicated the facility had, "... a power back up for 90-minutes..." yet he was unclear to what this provision was obtained from. He did indicate, "...we (the facility) do not have a generator, at all, at this location." On 11/29/12 at 11:00 am, an interview was conducted with the Administrator about the facility not having a generator and the provision for emergency back up power. He indicated at this time that, "...the last time we (the facility) lost power for several hours... at least four hours or so... we 'had' power for 90 minutes after the lights went out..." He indicated that he was not sure to what power remained on. He did note, "...the whole facility lost power... and we did just fine..." When questioned to what specifically the facility did to provide emergency electrical power to support lighting at the entrances and exits, equipment to maintain fire detection, alarm and extinguishing systems, he indicated, "... well... eventually it all came back on... I mean, the neighborhood was out too... not just us... we used flashlights... I don't understand, we just do what we can in a situation like that... what do you expect..." On 11/29/12 at 2:00 p.m., an interview		utilized during power losses. Fire systems are supported for twenty-four hours by a battery back-up. Battery powered emergency lighting is available throughout the facility and monitored with monthly audits. All staff will be in-serviced on the above policies. These new polices will be incorporated in new staff orientation process. **How the corrective actions will be monitored to ensure the deficient practice will not recur, what quality assurance measures program will be put into place:** Quarterly testing of the emergency systems will be completed by our contracted providers. Any concerns noted as a result of these test will be corrected and the results taken to the quarterly Q/A committee for review for two quarters. The committee will determine the need to review these reports beyond two quarters based upon a 10% error rate or higher of each report.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155752	A. BUILDING 00 B. WING	11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE NURSING AND MEMORY CARE CENTER	18325 BAILEY AVE SOUTH BEND, IN 46637

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	was conducted with the Administrator. He indicated that the facility did not experience a complete power outage as he had indicated earlier in the mornings' conversation, yet that,"... only certain portions of the facility was without power..." When inquiring about the specific areas of power outage, the Administrator was unclear and requested the Activities Director to provide clarity. On 11/29/12 at 2:15 p.m., an interview with the Activities Director was conducted. He indicated that with in the facility were emergency lights at the exits, along the hall corridors and secondary exits for staff. A color coded map with a coding for the fire and emergency exits was provided upon request. He did indicate that an electrical power source is required to operate these emergency systems. On 11/29/12 at 2:30 p.m. a record review was conducted of the 'Emergency Preparedness Plan' in conjunction with an electrical power outage plan for the facility. The following Policy and Procedures were supplied by the facility and reviewed for content. 1) "Loss of Fire Detection System & Sprinkler System Policy/ Fire Watch Procedure. Purpose: To define the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155752	A. BUILDING 00 B. WING	11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE NURSING AND MEMORY CARE CENTER	18325 BAILEY AVE SOUTH BEND, IN 46637

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	facility's guidelines for providing effective fire protection services to the residents, staff and building at all times. Guidelines: where a required fire alarm detection system and Sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified and an approved fire watch system will be provided for all parties left unprotected by the shutdown until the fire/alarm detection system and Sprinkler system has been returned to service. The watch is to be done every 15 minutes... Procedure: A. The Administrator or designee will: 1. Implement an approved fire watch. 2. Notify the Authority having jurisdiction: (phone number). 3. Notify the Administrator, Owner (phone number)..." 2) "Fire and Disaster Preparedness Policy... Standards...5. The Disaster Plans shall include processes for the following: a. Implementation of specific procedures for a variety of disasters including severe weather....internal and external emergencies which disrupt resident care, loss of utilities... 18. Emergency electrical power will be available from an emergency generator on the premises where life support systems are used, including suction machines to maintain an open airway. Emergency power system is adequate to provide for lighting of all			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155752	A. BUILDING 00 B. WING	11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE NURSING AND MEMORY CARE CENTER	18325 BAILEY AVE SOUTH BEND, IN 46637

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	entrance and exits, equipment to maintain fire detection, alarm and extinguishing systems On 11/29/12 at 2:35 p.m., an observation was made of an emergency suction machine located in the Main Dining room area. The suction machine operates on electricity and is used in an emergency to maintain an open airway. On 11/29/12 at 2:40 p.m. an 'Agreement', dated "2004", for the contracted service to supply the facility with an emergency generator was reviewed. A 3-way conference call was made to the supplier of the 'Agreement' and found that the service continued to be a provision for the facility. The Administrator indicated that the procedure for the facility to acquire the generator from this supplier would depend upon the Administrator and Owners discretion. He indicated that the staff and residents at the facility did not have a policy/ procedure to support their acquisition of this provision. When inquired about the process the facility would be expected to do if and when the Administrator was not available for his directive for emergency electrical power he indicated, he didn't know. There was not a policy and/or procedure provided about the process of emergency power preparedness provided at the survey.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155752	A. BUILDING 00 B. WING	11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE NURSING AND MEMORY CARE CENTER	18325 BAILEY AVE SOUTH BEND, IN 46637

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 11/29/12 at 2:45 p.m., a record review of the "Emergency Control of Utilities" was conducted. It indicated that the "Purpose" of this policy was, " To ensure facility staff have knowledge and use of emergency utility controls." Located under "Standards:... ...4. In the event of a power outage, the system to manage door locks will be released so that individuals may exit to safety... 5. Systems not covered by emergency power systems have written plans to ensure resident services are not significantly altered..." It was unclear to what these "written plans" were at the time of the survey process. On 11/29/12 between 3:30 p.m. and 4:15 p.m., interviews with the evening facility staff were conducted in regards to their knowledge of an emergency electrical power procedure and knowledge of the facility use of emergency back up power and generator usage. The interviews are as follows: 1. Dietary Aid #2 indicated when the facility has a power outage, they would report to their supervisor. 2. Cook #3 indicated they would help with resident care. 3. Dietary Manager indicated she would, "...call the power company..." She			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155752	A. BUILDING 00 B. WING	11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE NURSING AND MEMORY CARE CENTER	18325 BAILEY AVE SOUTH BEND, IN 46637

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated that the kitchen emergency electrical power is supplied to, "...one wall but not the other... it happened an entire week one time, so we strung an electrical cord from one wall to the other and draped the cord over the tops of the refrigerators and brought some frozen food over to the office area refrigerators... we did this until the electricity got fixed..." 4. CNA (Certified Nursing Assistant) #5 noted, "...usually... emergency lights go out... we tell the nurse and she tells us what to do..." 5. CNA#6 noted, "... the generator picks up... I'll try to get portable oxygen..." 6. CNA#7 noted, "...the generator resets and we make sure residents are safe..." 7. CNA #8 noted, "...we should learn this in the orientation process, but I didn't... I really don't know... we help with the portable oxygen... secure the backdoors... call the power company..." 8. LPN #9 noted, "...Call electric company, focus on resident care, assign the CNA's for resident care, provide care...yeah... we would call the Administrator at some point..." 9. LPN #10 noted, "...we have a back up generator... first 2-3 hours we have full power, then it goes down to emergency level... we used lanterns last time it happened... we double up with care for the residents... once the whole			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155752	A. BUILDING 00 B. WING	11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE NURSING AND MEMORY CARE CENTER	18325 BAILEY AVE SOUTH BEND, IN 46637

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	neighborhood was effected and we didn't have power for a long time until the neighborhoods power came back on... yeah... I'd call the power company to make sure it had been reported... yeah...we'd contact the administrator at some point...yes. 3.1-19(d) 3.1-19(e)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155752	A. BUILDING 00 B. WING	11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE NURSING AND MEMORY CARE CENTER	18325 BAILEY AVE SOUTH BEND, IN 46637

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0456 SS=F	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. Based on observation, interview, and record review, the facility failed to assure the ice machine was in working condition, periodically disinfected and cleaned. This potentially affected 35 of 35 Residents. Findings include: On 11/29/12 at 8:30 a.m., an observation was made of the ice machine located in the main dining room. It was observed to be used by the kitchen staff, the primary care staff working the resident halls and the primary care staff in the dining room area assisting the residents during breakfast. The ice machine was low on ice and it was observed when staff dipped into the ice machine holding chamber that they needed to lean into the ice holder area to reach the ice. The lid to the ice machine holding area was not locked nor had a lock to lock, yet had a male/ female adapter for use of a pad-lock-type lock. A sign was taped to the lid requesting all peoples using the ice machine to lock the holding area when finished. On 11/29/12 at 10:30 a.m., an observation was made with the Administrator and the	F0456	**F456 What corrective action will be accomplished for those residents found to have been affected by this deficient practice:** Infection control procedures will be followed to ensure the safety and well being of our residents. **How other residents having the potential having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:** All residents have the potential to be affected. Due to this new policies and monitoring systems have been developed for all staff to follow. **What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur:** An Ice Machine Sanitation policy was developed as well as a Cleaning and Sanitizing schedule according to the manufacturer's recommendations (see attachments 3&4). All staff will be in-serviced on the above policies. These new polices will be incorporated in new staff orientation process. **How the corrective actions will be monitored to ensure the deficient practice will not recur,**	12/30/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155752	A. BUILDING 00 B. WING	11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE NURSING AND MEMORY CARE CENTER	18325 BAILEY AVE SOUTH BEND, IN 46637

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Activities Director upon the environmental tour of the facility. The Activities Director indicated that the machine was in fact used by all the staff at the facility for resident care. He also indicated that the ice machine should be locked. The Administrator noted,"...we have a new ice machine arriving today..." On 11/29/12 at 11:30 a.m., a record review of the "purchase receipt of a new ice machine" was provided by the facility and reviewed. The receipt was a purchase price for a "used, labor 1599.00" and a "new with labor: 2452.00 half at installation, half in 30 days after installation day..." The provider for the service was at the header of the receipt. There was no date on the receipt. There was no indication that this was a purchase receipt yet rather a pricing quote for a new and/or used ice machine with installation and payment information. At 11:35 a.m., a call was made to the provider for the service for the ice machine. The vendor indicated that, "...2-3 weeks ago the facility had called requesting a service call for an ice machine at Morningside Facility having indicated it was not working properly...we (the service vendor) made a service call to the facility and worked on the ice machine. We (the vendor) informed the facility at that time that though we were		**what quality assurance measures program will be put into place:** Weekly checks to the cleaning schedule will occur to ensure the appropriate cleaning and sanitation is taking place. Staff will be observed as well to ensure they are following the facility's policy on retrieval of ice for resident consumption. Any concerns noted as a result of these observation and monitoring will be corrected and the results taken to the quarterly Q/A committee for review for two quarters. The committee will determine the need to review these reports beyond two quarters based upon a 10% error rate or higher of each report.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155752	A. BUILDING 00 B. WING	11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE NURSING AND MEMORY CARE CENTER	18325 BAILEY AVE SOUTH BEND, IN 46637

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	able to get their ice machine running again, it in no way indicated it was repaired. In fact, we could not tell them a time frame of when it would cease to run at all... their ice machine needed to be repaired which was going to cost more money in parts and labor than it would cost them to buy a new one outright. The Administrator was clearly informed of the situation with the older ice machine. The facility decided upon a new ice machine. The facility however was non decisive about the installment of the new ice machine... it's up to them now... there is no reason the new ice machine shouldn't be workable and installed within 1-2 days..." He indicated at that time that he was currently delivering the ice machine to the facility as we spoke. On 11/29/12 at 2:00 p.m., a record review was conducted of the "Monthly Compliance/ Comments" worksheet for the maintenance cleaning of the ice machine. It was dated, "10/1/12". It noted that the ice machine had been "delimed" on the date indicated. There was no records for routine cleaning and disinfecting of the ice machine. On 11/29/12 at 2:30 p.m., an interview was conducted with the DNS (Director of Nursing Service). She indicated that upon arriving to the facility on 11/26/12, that			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155752	A. BUILDING 00 B. WING	11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE NURSING AND MEMORY CARE CENTER	18325 BAILEY AVE SOUTH BEND, IN 46637

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	she was made aware that, "...the ice machine was broken..." She indicated that up until this point she had no idea that it wasn't working properly. She reiterated her hire date to this facility was 11/12/12. She indicated that ice had been being delivered to the facility for daily use due to the ice machine not working properly. She indicated she was not aware of how long this had been happening. On 11/30/12 at 3:45 p.m., a record review was conducted of a Registered Dietician having been located within a sampled employee file for review. It was dated, "8/28/12." It contained the following note: "...2. The man today working on the ice machine was not wearing gloves to clean out the lime within the tray on the machine. Please assess if this area could possibly become a contaminating source to the ice being produced. While the lime is not a contaminant, bear hands would be. Please consider scheduling a thorough cleaning and sanitizing of the machine after such "deep" maintenance in needed to prevent contamination of our highly immunosuppressed residents." This was signed by a Registered Dietician. On 11/30/12 at 3:45 p.m., a record review			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155752	A. BUILDING 00 B. WING	11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE NURSING AND MEMORY CARE CENTER	18325 BAILEY AVE SOUTH BEND, IN 46637

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	was provided for the, "Ice Chest/ Ice Scoop Cleaning and Disinfecting. Purpose: To clean and reduce the micro-organisms on an inanimate object rendering it safe for use. Policy: The ice chest shall be cleaned and sanitized each day by the Dietary Department. Standards: 1. The ice chest (container) and ice scoop shall be sent to the Dietary Department on the day shift. 2. Routine cleaning and sanitizing procedures shall be used. 3. When not in use the ice chest shall be closed and the ice scoop covered using a non-porous material. dated 11/26/1997)" On 11/30/12 at 3:50 p.m., an interview was conducted with the Administrator. He indicated there were no records for cleaning and disinfecting the 'old' ice machine. On 11/30/12 at 3:55 p.m., an observation was made of the ice machine in the main dining room. It was unchanged from the previous observations. A wooden skid with another piece of equipment noted to be the 'new' ice machine was on top of the wooden skid. Plastic wrap was littered around the 'new' ice machine. There was no evidence that the 'new' ice machine was running. On 11/30/12 at 3:56 p.m., an interview			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155752	A. BUILDING 00 B. WING	11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE NURSING AND MEMORY CARE CENTER	18325 BAILEY AVE SOUTH BEND, IN 46637

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	was made with the Dietary Manager. She indicated that the old ice machine was still operational. She noted, "...yep... it's still there... I'm not sure what all that is on the floor... I can tell you what they (the facility) can do with that ice machine..." On 11/30/12 at 4:00 p.m., an interview was conducted with the Administrator. It was indicated that the observation of the 'new' ice machine and the 'old' ice machine was unresolved. 3.1-19(bb)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155752	A. BUILDING 00 B. WING	11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE NURSING AND MEMORY CARE CENTER	18325 BAILEY AVE SOUTH BEND, IN 46637

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. Based on interview and record review, the facility failed to ensure a laboratory test was obtained as ordered by the resident's Physician. This deficiency affected 1 of 10 residents reviewed for laboratory test in a sample of 16 (Resident #17). Findings include: The clinical record of Resident #17 was reviewed on 11/29/12 at 12:00 p.m., indicated Resident #17 diagnosis included, but were not limited to, atrial fibrillation (irregular heart beat). The Physician's Order Sheet, dated November 2012, for Resident #17 indicated to obtain the laboratory test Digoxin every 3 months ordered on 2/14/11. The laboratory test results for Digoxin had been drawn on 2/1/12, and indicated the result was low at 0.4. There were no other laboratory test results for the Digoxin levels in the chart. On 11/30/12 at 9:00 a.m., an interview with the Director of Nursing (DON)	F0502	**F502 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** The physician and family were notified of the deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** A complete audit will be conducted by the Director of Nursing or designee of all current lab orders. This list will be cross-referenced with the South Bend Medical Foundations current order verification list to ensure that all active lab orders have been transcribed correctly and ordered. Prescriber notification of the results will also be audited to ensure timeliness and accuracy. This audit will be completed by 12/20/12. (Documented on the laboratory order audit sheet, Attachment 5A) The physician and family of any resident who is found to be affected by this deficient practice will be notified. If new orders are received, they will be followed through promptly. **What measures will be put into pace**	12/30/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155752	A. BUILDING 00 B. WING	11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE NURSING AND MEMORY CARE CENTER	18325 BAILEY AVE SOUTH BEND, IN 46637

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated she had looked through Resident #17's chart and had notified the laboratory and was unable to find any further Digoxin laboratory test results. The DON indicated she had only been employed at the facility for the past 3 weeks. The Nurse's Notes, dated 11/30/12 at 3:00 p.m., indicated Resident #17's Physician was notified and had ordered a Digoxin level to be drawn on 12/3/12. 3.1-49(a)		**or what systemic changes will be made to ensure that the deficient practice does not recur:** The facility nursing policy entitled "Laboratory tests processing and reporting" has been reviewed and updated. (See attachment 5B). (Refer to Omnicare, Inc. Suggested Laboratory Monitoring Parameters for Selected Medications 2012 for recommended laboratory monitoring parameters for commonly used medications. All licensed nurses will be in-serviced on the updated policy for laboratory tests processing and reporting on 12/21/12. (See attachment 5C). New nursing staff orientation will include hands on training for lab order processing (See attachments 5D&5E). The Director of Nursing or designated agent will audit the newly ordered labs and lab results weekly x 4 weeks ending 1/18/13 to ensure ongoing compliance with the updated laboratory processing policy. **How the corrective action(S) will be monitored to ensure the deficient practice will not recur. What quality assurance program will be put into place:** Subsequent audits will occur monthly to ensure continued compliance. The DON will forward the audit results to the Administrator for review. The Administrator will track and trend the data results and will submit	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155752	A. BUILDING 00 B. WING	11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE NURSING AND MEMORY CARE CENTER	18325 BAILEY AVE SOUTH BEND, IN 46637

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			the results quarterly at the QA Committee meeting for further review and recommendation. The Q/A Committee will determine the need for audits beyond six months of compliance if an error margin of 5% or greater exists. **What date will the systemic changes be completed.** Systemic changes will be completed by 12/21/12.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155752	A. BUILDING 00 B. WING	11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE NURSING AND MEMORY CARE CENTER	18325 BAILEY AVE SOUTH BEND, IN 46637

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0520 SS=C	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. Based on interviews and record reviews the facility failed to assure that the quality assessment and assurance (QAA) committee consisted of the required members. This had the potential to affect 35 of 35 residents residing in the facility. Findings include: On 11/26/12 at 11:00 a.m., an interview was conducted with the Administrator upon entry to the survey process. He	F0520	**F520 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** No residents were affected by this deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** No residents were affected by this deficient practice. **What measures will be put into**	12/30/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155752	A. BUILDING 00 B. WING	11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE NURSING AND MEMORY CARE CENTER	18325 BAILEY AVE SOUTH BEND, IN 46637

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	noted, "...yeah...I guess 'I' can be (the quality assessment and assurance committee name of contact for the facility)...uh...we have... myself, the doctor...we meet quarterly...I think..." On 11/26/12 at 12:00 p.m., a record review was conducted of the members of the facility's QAA committee. It noted the Medical Director, a Pharmacy Consultant, the DON (director of Nursing service), and the HFA (Administrator). It noted the meetings were held "quarterly." On 11/27/12 at 11:00 a.m., an interview was conducted with the Administrator. He indicated that the, "DON will be the QAA contact..." On 11/28/12 at 2:00 p.m.,. a record review was conducted of a signature sign-in page for a QAA meeting for the facility dates "10/26/12." It consisted of 4 signatures: the previous DON, the current Administrator, the Medical Director and the Pharmacy Consultant. On 11/29/12 at 2:00 p.m., an interview was conducted with the DON. She indicated the QAA committee would consist of a, "MD (Medical Director, DON, Administrator, Consultant Pharmacist, MDS (Minimum Data Set assessment nurse) and Social Worker		**pace or what systemic changes will be made to ensure that the deficient practice does not recur:** The facility nursing policy entitled "Quality Assurance Committee Policy" was revised and updated (See attachment 6). Per the policy the membership is to include the Administrator, Director of Nursing, Medical Director, Pharmacist, Activity Director, Social Services Director, Food Service Supervisor, and Consultants as requested. **How the corrective action(S) will be monitored to ensure the deficient practice will not recur. What quality assurance program will be put into place:** The management staff of the facility met on 12/7/12 to discuss the structure of the QAA committee. Each committee member was assigned **What date will the systemic changes be completed.** Systemic changes will be completed by 12/21/12.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155752	A. BUILDING 00 B. WING	11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE NURSING AND MEMORY CARE CENTER	18325 BAILEY AVE SOUTH BEND, IN 46637

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(SW)." She indicated that she was newly appointed to her position as the DON with this facility. She had not been associated with this corporation or facility prior to 3 weeks from this date of interview. She indicated that she was not familiar with the QAA committees dealings up to this point. 3.1-52(a)(3)			